

1 EDMUND G. BROWN, Attorney General
of the State of California
2 GLORIA A. BARRIOS
Supervising Deputy Attorney General
3 LINDA L. SUN, State Bar No. 207108
Deputy Attorney General
4 California Department of Justice
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-6375
6 Facsimile: (213) 897-2804

7 Attorneys for Complainant

8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 2009-32

12 **ROBERTA J. SCOTT**
82 N. Joanne Ave.
13 Ventura, CA 93003

A C C U S A T I O N

14 Registered Nurse License No. 319301
Public Health Nurse Certificate No. 44162

15
16 Respondent.

17 Complainant alleges:

18 **PARTIES**

19 1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation
20 solely in her official capacity as the Executive Officer of the Board of Registered Nursing
21 ("Board"), Department of Consumer Affairs.

22 2. On or about August 31, 1980, the Board issued Registered Nurse License
23 No. 319301 to Roberta J. Scott ("Respondent"). Said license was in full force and effect at all
24 times relevant to the charges brought herein and will expire on October 31, 2009, unless
25 renewed.

26 3. On or about November 25, 1988, the Board issued Public Health Nurse
27 Certificate No. 44162 to Respondent. Said certificate was in full force and effect at all times
28 relevant to the charges brought herein and will expire on October 31, 2009, unless renewed.

1
2
3
4
5
6
7
8
9
0
1
2
3
4
5
6
7
8
9
0
1
2
3
4
5
6
7
8

4. This Accusation is brought before the Board, under the authority of the

5

5. Section 2750 of the Code provides, in pertinent part, that the Board may

6. Section 2764 of the Code provides, in pertinent part, that the expiration of

7. Section 822 of the Code provides, in pertinent part:

“If a licensing agency determines that its licensee’s ability to practice his or her

18

19

20

“(d) Taking such other action in relation to the licentiate as the licensing agency in

23

“(a) Each registered nurse who requests participation in a diversion program shall

1 enforcement program.

2 “(b) If a committee determines that a registered nurse, who is denied admission
3 into the program or terminated from the program, presents a threat to the public or his or her own
4 health and safety, the committee shall report the name and license number, along with a copy of
5 all diversion records for that registered nurse, to the board’s enforcement program. The board
6 may use any of the records it receives under this subdivision in any disciplinary proceeding.”

7 9. Section 2761 of the Code states:

8 “The board may take disciplinary action against a certified or licensed nurse or
9 deny an application for a certificate or license for any of the following:

10 “(a) Unprofessional conduct, which includes, but is not limited to, the following:

11 “(1) Incompetence, or gross negligence in carrying out usual certified or licensed
12 nursing functions.”

13 10. California Code of Regulations, title 16, section 1442 states:

14 “As used in Section 2761 of the Code, ‘gross negligence’ includes an extreme
15 departure from the standard of care, which, under similar circumstances, would have ordinarily
16 been exercised by a competent registered nurse. Such an extreme departure means the failure to
17 provide nursing care as required or failure to provide care or to exercise ordinary precaution in a
18 single situation in which the nurse knew, or should have known, could have jeopardized the
19 client’s health or life.”

20 11. California Code of Regulations, title 16, section 1443 states:

21 “As used in Section 2761 of the code, ‘incompetence’ means the lack of
22 possession of or the failure to exercise that degree of learning, skill, care and experience
23 ordinarily possessed and exercised by a competent registered nurse as described in Section
24 1443.5.”

25 12. California Code of Regulations, title 16, section 1443.5 states:

26 “A registered nurse shall be considered to be competent when he/she consistently
27 demonstrates the ability to transfer scientific knowledge from social, biological and physical
28 sciences in applying the nursing process, as follows:

1 “(1) Formulates a nursing diagnosis through observation of the client's physical
2 condition and behavior, and through interpretation of information obtained from the client and
3 others, including the health team.

4 “(2) Formulates a care plan, in collaboration with the client, which ensures that
5 direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and
6 protection, and for disease prevention and restorative measures.

7 “(3) Performs skills essential to the kind of nursing action to be taken, explains
8 the health treatment to the client and family and teaches the client and family how to care for the
9 client's health needs.

10 “(4) Delegates tasks to subordinates based on the legal scopes of practice of the
11 subordinates and on the preparation and capability needed in the tasks to be delegated, and
12 effectively supervises nursing care being given by subordinates.

13 “(5) Evaluates the effectiveness of the care plan through observation of the client's
14 physical condition and behavior, signs and symptoms of illness, and reactions to treatment and
15 through communication with the client and health team members, and modifies the plan as
16 needed.

17 “(6) Acts as the client's advocate, as circumstances require, by initiating action to
18 improve health care or to change decisions or activities which are against the interests or wishes
19 of the client, and by giving the client the opportunity to make informed decisions about health
20 care before it is provided.”

21 13. Section 125.3 of the Code provides, in pertinent part, that the Board may
22 request the administrative law judge to direct a licentiate found to have committed a violation or
23 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation
24 and enforcement of the case.

25 ///

26 ///

27 ///

28 ///

FACTUAL STATEMENT

14. From on or about October 25, 1993 to on or about August 25, 2003, Respondent was employed as a registered nurse with the Ventura County Public Health Department.

15. On or about October 15, 2001, Respondent transferred to public health nursing in the Community Health Services Division as a tuberculosis ("TB") Public Health Nurse ("PHN"). Respondent's duties as a PHN included TB contact investigation as well as case management activities for private medical doctor cases, which included communication and follow-up.

16. From approximately October 26, 2001 through May 1, 2002, Respondent demonstrated the following with respect to her job performance: failure to maintain charts, failure to communicate important TB information to the TB office in a timely manner, difficulty focusing on job duties, and failure to follow-up properly on TB cases. Due to Respondent's pattern of behavior, a chart audit was conducted of Respondent's TB cases. Twenty-three (23) charts involving seventy-four (74) clients with possible TB infection were audited. The following findings were made regarding Respondent's case audit:

a. Respondent had 100% deficiencies in all of her TB contact investigation charts in that Respondent either failed to document or did not follow up with patients and their families diagnosed with TB to ensure their compliance with the medical treatment regimen.

b. Respondent functioned outside the TB PHN protocol by ordering laboratory tests and x-rays on suspect clients without physicians' orders, questioning physicians' diagnosis by interpreting chest x-rays and other diagnostics on her own, providing medical conclusions to the patients without consulting with a physician, failing to keep the assigned physicians informed of the patients' conditions, and refusing to follow physicians' orders based on her own interpretation of case findings.

17. Following the case audit, on or about May 1, 2002, Respondent was transferred from the TB field nursing position to a general field nursing position. Respondent's direct supervisor, a Resource Specialist PHN, observed the following behavior by Respondent:

1 rapid pressured speech, tangential thinking with great difficulty in keeping focused on the task at
2 hand, poor judgment in field safety, and verbalizing her self-importance and expertise as the only
3 nurse who knows TB.

4 18. Based on the above incidents set forth paragraphs 16 and 17, Respondent's
5 supervisors believed that Respondent was not safe to practice autonomously in the community as
6 a PHN. On or about May 14, 2002, Respondent was placed on paid administrative leave and
7 instructed to seek medical attention and to provide documentation that she was capable of
8 performing her job functions as a public health nurse.

9 19. On or about July 16, 2002, Respondent enrolled in the Board's Diversion
10 Program ("Program"). Through the Program, Respondent was diagnosed with major depressive
11 disorder, Bipolar Disorder II, and Attention Deficit Disorder. On or about December 11, 2003,
12 Respondent was terminated from the Program as a public safety risk for non-compliance in that
13 Respondent began working as an RN without Program approval.

14 20. On or about August 25, 2003, Respondent was terminated from her PHN
15 position with the County of Ventura for incompetency, acts which are incompatible with public
16 service, and acts which are inimical to the public service. Respondent failed to notify the County
17 of Ventura that she was participating in the Board's Diversion Program or that she had work
18 restrictions through that Program, until approximately one year after Respondent had enrolled in
19 the Program.

20 **FIRST CAUSE FOR DISCIPLINE**

21 **(Unprofessional Conduct: Gross Negligence and/or Incompetence)**

22 21. Respondent's license is subject to disciplinary action under Business and
23 Professions Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct in
24 that Respondent's conduct was incompetent and/or grossly negligent within the meaning of
25 California Code of Regulations, title 16, sections 1442 and 1443, and as defined in California
26 Code of Regulations, title 16, section 1443.5, in that while employed as a registered nurse and
27 PHN with the Ventura County Public Health Department, Respondent failed to provide care or
28 exercise ordinary precaution, which she knew or should have known could jeopardize patients'

1 lives or health. The circumstances regarding Respondent's conduct are set forth above in
2 paragraphs 14 to 20 and incorporated herein by reference, and are further set forth as follows:

3 a. Respondent committed gross negligence in that she failed to follow-up
4 with newly diagnosed TB patients to ensure compliance with the highly rigorous medication
5 protocols necessary for containment and treatment of the disease. Respondent had 100%
6 deficiencies in all of her TB contact investigation charts.

7 b. Respondent committed gross negligence and incompetence in that she
8 engaged in physician's responsibilities by initiating x-rays and laboratory work for patients
9 without physician's orders. This conduct was beyond the scope of her nursing practice, and
10 outside of departmental protocols.

11 c. Respondent committed gross negligence and incompetence in that she
12 failed to collaborate with the health care team, failed to utilize departmental protocols, and failed
13 to adhere to an evidence-based practice. Respondent instead relied solely on her own
14 interpretation of events and diagnostic data in the care and treatment of her TB patients.

15 d. Respondent committed gross negligence and incompetence in that she
16 attempted to supercede the authority of her departmental supervisor, as well as that of the
17 Board's Diversion Program by returning to work without Program approval, which demonstrates
18 a disregard for the laws and structure that govern the nursing practice and is reflective of
19 consistently poor judgment. Such behavior places the patients at risk in that Respondent is
20 unable to collaborate, share data, or work within the confines of her license.

21 **SECOND CAUSE FOR DISCIPLINE**

22 **(Impaired Ability To Practice)**

23 22. Respondent is subject to discipline under section 822 of the Code in that
24 Respondent's ability to practice nursing safely is impaired. On October 25, 2007, in case number
25 2008-142, entitled *In the Matter of the Petition to Compel Psychiatric Examination of Roberta J.*
26 *Scott*, the Board ordered Respondent to undergo a psychiatric examination pursuant to Code
27 section 820. (A copy of the Petition and Order is attached as Exhibit A and incorporated herein
28 by reference.) Pursuant to the examination, the evaluator determined that Respondent was and

1 continues to be impaired in her ability to practice nursing safely.

2 **FACTORS IN AGGRAVATION**

3 23. On or about July 16, 2002, Respondent entered into the Board's Diversion
4 Program. On or about December 11, 2003, Respondent was terminated from the Program as a
5 public safety risk for non-compliance with the required mandates, by practicing registered
6 nursing without program approval.

7 **PRAYER**


8 WHEREFORE, Complainant requests that a hearing be held on the matters herein
9 alleged and that, following the hearing, the Board issue a decision:

10 24. Revoking or suspending Registered Nurse License No. 319301 and Public
11 Health Nurse Certificate No. 44162 issued to Roberta J. Scott;

12 25. Ordering Roberta J. Scott to pay the Board the reasonable costs of the
13 investigation and enforcement of this case, pursuant to Business and Professions Code section
14 125.3.

15 26. Taking such other and further action as deemed necessary and proper.

16
17 DATED: 8/12/08

18
19 
20 RUTH ANN TERRY, M.P.H., R.N.
21 Executive Officer
22 Board of Registered Nursing
23 Department of Consumer Affairs
24 State of California
25 Complainant

26
27 Exhibit A: Petition and Order to Compel Psychiatric Examination of Roberta J. Scott

28
LA2006601594
~6889647.wpd